

WORKSHEET S  
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	14-4009	I	FROM 1/ 1/2009	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
					I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORTDATE: 4/12/2010 TIME 13:24

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:  
RIVER EDGE HOSPITAL 14-4009  
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2009 AND ENDING 12/31/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION  
DATE: 4/12/2010 TIME 13:24

x2ewkVnJ3R2wc03R1y8ZPlhl.TVqp0  
OowEW0Stc3YuuGmkSewg9Cu8bPJ0B8  
h6w.001zzM0ULQ3d

PI ENCRYPTION INFORMATION  
DATE: 4/12/2010 TIME 13:24

t1:NegSsUHqLfBv3EFN1Evuwau0Hh0  
OWS.R0:yT9Eecn0Y06PICf73K8x:gC  
VHKf2kf1up0E49kk

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

TITLE V		TITLE XVIII		TITLE XIX	
1	2	3	4	5	6
1	0	-85,084	0	-46,200	
100	0	-85,084	0	-46,200	
HOSPITAL					
TOTAL					

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX  
IDENTIFICATION DATAI PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
I 14-4009 I FROM 1/ 1/2009 I WORKSHEET S-2  
I I TO 12/31/2009 I

## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 8311 WEST ROOSEVELT ROAD  
1.01 CITY: FOREST PARK

P.O. BOX:

STATE: IL

ZIP CODE: 60130-

COUNTY: COOK

## HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)
0	1	2	2.01	3	V XVIII XIX
02.00 HOSPITAL	RIVER EDGE HOSPITAL	14-4009		7/ 1/1967	4 5 6 N P O

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2009

TO: 12/31/2009

1 2  
4

18 TYPE OF CONTROL

## TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL  
20 SUBPROVIDER

4

## OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.

1

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.

N N

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.

1 N

N 16974

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL

1

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL

1

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA \$5105 OR MIPPA \$147? (SEE INSTRU) ENTER "Y" FOR YES, AND "N" FOR NO.

N

21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA \$147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)

N

21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.

3 N

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER?

N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.

N

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.

/ / / /

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.

/ / / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY)

/ /

24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy).

/ /

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I I TO 12/31/2009 I

25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING  
PAYMENTS FOR I&R? N

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? N

25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN  
EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET  
E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.

25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS  
DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N

25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N

25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED  
UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR  
NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE  
RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y"  
FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT  
IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.  
SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913  
FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. N / /

28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR  
THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1.  
ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE  
OCTOBER 1ST (SEE INSTRUCTIONS)

	1	2	3	4
28.02	0	0.0000	0.0000	
	0.00	0		

28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL  
INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER  
THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR  
TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE  
OR TWO CHARACTER CODE IF RURAL BASED FACILITY

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN  
INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE  
USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL  
EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN  
3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES  
ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

	%	Y/N
28.03 STAFFING	0.00%	
28.04 RECRUITMENT	0.00%	
28.05 RETENTION	0.00%	
28.06 TRAINING	0.00%	

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE  
AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N

30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS  
HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) N

30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH?  
SEE 42 CFR 413.70

30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF  
PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)

30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBILE FOR COST REIMBURSEMENT FOR AMBULANCE  
SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST  
BE ON OR AFTER 12/21/2000).

30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBILE FOR COST REIMBURSEMENT FOR I&R  
TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD  
NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF  
YES COMPLETE WORKSHEET D-2, PART II

31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42  
CFR 412.113(c). N

31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42  
CFR 412.113(c). N

31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42  
CFR 412.113(c). N

31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42  
CFR 412.113(c). N

31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42  
CFR 412.113(c). N

31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42  
CFR 412.113(c). N

MISCELLANEOUS COST REPORT INFORMATION

32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N

33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO  
IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO  
YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR  
NO IN COLUMN 2

34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N

35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX  
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I I TO 12/31/2009 I

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

	V	XVIII	XIX
36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	1	2	3
36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N
37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?	N	N	N

## TITLE XIX INPATIENT SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y

38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? Y

38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N

38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N

38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS). Y

40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #

40.02 STREET: P.O. BOX:

40.03 CITY: STATE: ZIP CODE: -

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y

42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N

42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N

42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N

43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N

44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N

45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000

SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.

45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS? N

45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? N

45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD? N

46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	N	N	N	N	N

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N

52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N

53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

53.01 MDH PERIOD: BEGINNING: / / ENDING: / /

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:

PREMIUMS: 0

PAID LOSSES: 0

AND/OR SELF INSURANCE: 0

54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N

55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.

	DATE	Y OR N	LIMIT	Y OR N	FEES
	0	1	2	3	4
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.		N	0.00		0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

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I 14-4009 I FROM 1/ 1/2009 I WORKSHEET S-2  
I I TO 12/31/2009 I

- 57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
- 58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER?  
ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100%  
FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS  
ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE  
10/1/2002. N
- 58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST  
REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS  
THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC.  
412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER  
1, 2 OR 3 RESPECTIVELY IN COLUMN 3. (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD  
COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS  
OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). N
- 59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO.  
IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2  
"Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
- 60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?  
ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW  
FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) Y N
- 60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN  
THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y"  
FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN  
ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(c)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF  
COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST  
REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT  
ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC). N N 0

MULTICAMPUS

- 61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA?  
ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3,  
CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

- 63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS  
ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH"  
DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). / /

HOSPITAL AND HOSPITAL HEALTH CARE  
COMPLEX STATISTICAL DATA

I PROVIDER NO:	I PERIOD:	I PREPARED	4/12/2010
I 14-4009	I FROM 1/ 1/2009	I WORKSHEET	S-3
I	I TO 12/31/2009	I PART	I

COMPONENT		NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH N/A 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	196	71,540			6,118		21,212
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	196	71,540			6,118		21,212
12	TOTAL	196	71,540			6,118		21,212
13	RPCH VISITS							
17	OTHER LONG TERM CARE	14	5,110					
25	TOTAL	210						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

COMPONENT		I/P DAYS / TITLE XIX OBSERVATION BEDS ADMITTED NOT ADMITTED		O/P VISITS TOTAL ALL PATS	TRIPS TOTAL OBSERVATION BEDS ADMITTED NOT ADMITTED		INTERNS & RES. FTES -- LESS I&R REPL NON-PHYS ANES	
		5.01	5.02	6	6.01	6.02	7	8
1	ADULTS & PEDIATRICS			31,406				
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS			31,406				
12	TOTAL			31,406				
13	RPCH VISITS							
17	OTHER LONG TERM CARE			4,851				
25	TOTAL							
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

COMPONENT		I & R FTES NET	--- FULL TIME EQUIV --- EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
		9	10	11				
1	ADULTS & PEDIATRICS					508	1,341	2,308
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		220.11			508	1,341	2,308
13	RPCH VISITS							
17	OTHER LONG TERM CARE		15.57					5
25	TOTAL		235.68					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

## HOSPITAL WAGE INDEX INFORMATION

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET S-3  
 I I TO 12/31/2009 I PARTS II & III

PART II - WAGE DATA	AMOUNT REPORTED 1	RECLASS OF SALARIES 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	DATA SOURCE 6
SALARIES						
1 TOTAL SALARY	11,683,904		11,683,904			
2 NON-PHYSICIAN ANESTHETIST PART A						
3 NON-PHYSICIAN ANESTHETIST PART B						
4 PHYSICIAN - PART A						
4.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
5 PHYSICIAN - PART B						
5.01 NON-PHYSICIAN - PART B						
6 INTERNS & RESIDENTS (APPRVD)						
6.01 CONTRACT SERVICES, I&R						
7 HOME OFFICE PERSONNEL						
8 SNF						
8.01 EXCLUDED AREA SALARIES	635,430	360,408	995,838			
OTHER WAGES & RELATED COSTS						
9 CONTRACT LABOR:						
9.01 PHARMACY SERVICES UNDER CONTRACT						
9.02 LABORATORY SERVICES UNDER CONTRACT						
9.03 MANAGEMENT & ADMINISTRATIVE UNDER CONTRACT						
10 CONTRACT LABOR: PHYS PART A						
10.01 TEACHING PHYSICIAN UNDER CONTRACT (SEE INSTRUCTIONS)						
11 HOME OFFICE SALARIES & WAGE RELATED COSTS						
12 HOME OFFICE: PHYS PART A						
12.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
WAGE RELATED COSTS						
13 WAGE-RELATED COSTS (CORE)						CMS 339
14 WAGE-RELATED COSTS (OTHER)						CMS 339
15 EXCLUDED AREAS						CMS 339
16 NON-PHYS ANESTHETIST PART A						CMS 339
17 NON-PHYS ANESTHETIST PART B						CMS 339
18 PHYSICIAN PART A						CMS 339
18.01 PART A TEACHING PHYSICIANS						CMS 339
19 PHYSICIAN PART B						CMS 339
19.01 WAGE-RELATED COSTS (RHC/FQHC)						CMS 339
20 INTERNS & RESIDENTS (APPRVD)						CMS 339
OVERHEAD COSTS - DIRECT SALARIES						
21 EMPLOYEE BENEFITS	148,301		148,301			
22 ADMINISTRATIVE & GENERAL	2,101,901	-360,408	1,741,493			
22.01 A & G UNDER CONTRACT						
23 MAINTENANCE & REPAIRS						
24 OPERATION OF PLANT	132,834		132,834			
25 LAUNDRY & LINEN SERVICE						
26 HOUSEKEEPING						
26.01 HOUSEKEEPING UNDER CONTRACT						
27 DIETARY	246,356		246,356			
27.01 DIETARY UNDER CONTRACT						
28 CAFETERIA						
29 MAINTENANCE OF PERSONNEL						
30 NURSING ADMINISTRATION	976,987		976,987			
31 CENTRAL SERVICE AND SUPPLY						
32 PHARMACY						
33 MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	204,535		204,535			
34 SOCIAL SERVICE	900,019		900,019			
35 OTHER GENERAL SERVICE						
PART III - HOSPITAL WAGE INDEX SUMMARY						
1 NET SALARIES	11,683,904		11,683,904			
2 EXCLUDED AREA SALARIES	635,430	360,408	995,838			
3 SUBTOTAL SALARIES	11,048,474	-360,408	10,688,066			
4 SUBTOTAL OTHER WAGES & RELATED COSTS						
5 SUBTOTAL WAGE-RELATED COSTS						
6 TOTAL	11,048,474	-360,408	10,688,066			
7 NET SALARIES						
8 EXCLUDED AREA SALARIES						
9 SUBTOTAL SALARIES						
10 SUBTOTAL OTHER WAGES & RELATED COSTS						
11 SUBTOTAL WAGE-RELATED COSTS						
12 TOTAL						
13 TOTAL OVERHEAD COSTS	4,710,933	-360,408	4,350,525			

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSESI PROVIDER NO:  
I 14-4009  
II PERIOD:  
I FROM 1/ 1/2009  
I TO 12/31/2009I PREPARED 4/12/2010  
I WORKSHEET A  
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		825,730	825,730	51,559	877,289
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		37,707	37,707	10,005	47,712
5	0500 EMPLOYEE BENEFITS	148,301	1,194,161	1,342,462	6,631	1,349,093
6	0600 ADMINISTRATIVE & GENERAL	2,101,901	4,879,213	6,981,114	-899,823	6,081,291
8	0800 OPERATION OF PLANT	132,834	867,056	999,890	16,538	1,016,428
9	0900 LAUNDRY & LINEN SERVICE		134,123	134,123		134,123
10	1000 HOUSEKEEPING		510,045	510,045		510,045
11	1100 DIETARY	246,356	521,735	768,091		768,091
12	1200 CAFETERIA					
14	1400 NURSING ADMINISTRATION	976,987	242,713	1,219,700	8,496	1,228,196
17	1700 MEDICAL RECORDS & LIBRARY	204,535	180,348	384,883		384,883
18	1800 SOCIAL SERVICE	900,019	140,518	1,040,537		1,040,537
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	5,978,842	734,821	6,713,663	310,367	7,024,030
36	3600 OTHER LONG TERM CARE	635,430	94,155	729,585		729,585
	ANCILLARY SRVC COST CNTRS					
41	4100 RADIOLOGY-DIAGNOSTIC					
44	4400 LABORATORY		165,012	165,012		165,012
53	5300 ELECTROCARDIOLOGY					
56	5600 DRUGS CHARGED TO PATIENTS		833,874	833,874		833,874
59	3950 OUTPATIENT PSYCH					
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	358,699	35,038	393,737		393,737
	SPEC PURPOSE COST CENTERS					
95	SUBTOTALS	11,683,904	11,396,249	23,080,153	-496,227	22,583,926
	NONREIMBURS COST CENTERS					
98	9800 PHYSICIANS' PRIVATE OFFICES					
100	7950 COMMUNITY RELATIONS				496,227	496,227
101	TOTAL	11,683,904	11,396,249	23,080,153	-0-	23,080,153

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:

I 14-4009

I

I PERIOD:

I FROM 1/ 1/2009

I TO 12/31/2009

I

I PREPARED 4/12/2010

I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	228,353	1,105,642
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	191,905	239,617
5	0500	EMPLOYEE BENEFITS	-112,344	1,236,749
6	0600	ADMINISTRATIVE & GENERAL	-2,211,051	3,870,240
8	0800	OPERATION OF PLANT	-1,350	1,015,078
9	0900	LAUNDRY & LINEN SERVICE		134,123
10	1000	HOUSEKEEPING		510,045
11	1100	DIETARY	-21,181	746,910
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION	-45,742	1,182,454
17	1700	MEDICAL RECORDS & LIBRARY	-1,299	383,584
18	1800	SOCIAL SERVICE	-4,526	1,036,011
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-344,122	6,679,908
36	3600	OTHER LONG TERM CARE	-913	728,672
		ANCILLARY SRVC COST CNTRS		
41	4100	RADIOLOGY-DIAGNOSTIC		
44	4400	LABORATORY		165,012
53	5300	ELECTROCARDIOLOGY		
56	5600	DRUGS CHARGED TO PATIENTS		833,874
59	3950	OUTPATIENT PSYCH		
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC		393,737
		SPEC PURPOSE COST CENTERS		
95		SUBTOTALS	-2,322,270	20,261,656
		NONREIMBURS COST CENTERS		
98	9800	PHYSICIANS' PRIVATE OFFICES		
100	7950	COMMUNITY RELATIONS		496,227
101		TOTAL	-2,322,270	20,757,883

## COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
I 14-4009 I FROM 1/ 1/2009 I NOT A CMS WORKSHEET  
I I TO 12/31/2009 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
53	ELECTROCARDIOLOGY	5300	
56	DRUGS CHARGED TO PATIENTS	5600	
59	OUTPATIENT PSYCH	3950	OTHER ANCILLARY SERVICE COST CENTERS
	OUTPAT SERVICE COST		
60	CLINIC	6000	
	SPEC PURPOSE COST CE		
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	COMMUNITY RELATIONS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

## RECLASSIFICATIONS

 PROVIDER NO:  
 144009

 PERIOD:  
 FROM 1/ 1/2009  
 TO 12/31/2009

 PREPARED 4/12/2010  
 WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 2	INCREASE		SALARY 4	OTHER 5
			LINE NO 3			
1 LEASE\RENTAL	A	NEW CAP REL COSTS-BLDG & FIXT	3			43,309
2						
3						
4 PHYSICIAN COST	B	ADULTS & PEDIATRICS	25			310,367
5 COMMUNITY RELATIONS	C	COMMUNITY RELATIONS	100		360,408	135,819
6 INSURANCE	D	NEW CAP REL COSTS-BLDG & FIXT	3			8,250
7 INTEREST	F	NEW CAP REL COSTS-MVBLE EQUIP	4			10,005
8 ADMINISTRATION MISCELLANEOUS	G	EMPLOYEE BENEFITS	5			6,631
9		OPERATION OF PLANT	8			31,538
10		NURSING ADMINISTRATION	14			11,380
36 TOTAL RECLASSIFICATIONS					360,408	557,299

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.  
 Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.  
 See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

## RECLASSIFICATIONS

 PROVIDER NO:  
144009

 PERIOD:  
FROM 1/ 1/2009  
TO 12/31/2009

 PREPARED 4/12/2010  
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 LEASE\RENTAL	A	ADMINISTRATIVE & GENERAL	6			25,425	10
2		OPERATION OF PLANT	8			15,000	10
3		NURSING ADMINISTRATION	14			2,884	
4 PHYSICIAN COST	B	ADMINISTRATIVE & GENERAL	6			310,367	
5 COMMUNITY RELATIONS	C	ADMINISTRATIVE & GENERAL	6		360,408	135,819	
6 INSURANCE	D	ADMINISTRATIVE & GENERAL	6			8,250	12
7 INTEREST	F	ADMINISTRATIVE & GENERAL	6			10,005	11
8 ADMINISTRATION MISCELLANEOUS	G	ADMINISTRATIVE & GENERAL	6			49,549	
9							
10							
36 TOTAL RECLASSIFICATIONS					360,408	557,299	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.  
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.  
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

## RECLASSIFICATIONS

 PROVIDER NO:  
144009

PERIOD:

FROM 1/ 1/2009

TO 12/31/2009

PREPARED 4/12/2010

WORKSHEET A-6

NOT A CMS WORKSHEET

 RECLASS CODE: A  
EXPLANATION : LEASE\RENTAL

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	43,309
2.00			0
3.00			0
TOTAL RECLASSIFICATIONS FOR CODE A			43,309

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	25,425	
OPERATION OF PLANT	8	15,000	
NURSING ADMINISTRATION	14	2,884	
		43,309	

 RECLASS CODE: B  
EXPLANATION : PHYSICIAN COST

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	310,367
TOTAL RECLASSIFICATIONS FOR CODE B			310,367

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	310,367	
		310,367	

 RECLASS CODE: C  
EXPLANATION : COMMUNITY RELATIONS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	COMMUNITY RELATIONS	100	496,227
TOTAL RECLASSIFICATIONS FOR CODE C			496,227

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	496,227	
		496,227	

 RECLASS CODE: D  
EXPLANATION : INSURANCE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	8,250
TOTAL RECLASSIFICATIONS FOR CODE D			8,250

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	8,250	
		8,250	

 RECLASS CODE: F  
EXPLANATION : INTEREST

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	10,005
TOTAL RECLASSIFICATIONS FOR CODE F			10,005

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	10,005	
		10,005	

 RECLASS CODE: G  
EXPLANATION : ADMINISTRATION MISCELLANEOUS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	EMPLOYEE BENEFITS	5	6,631
2.00	OPERATION OF PLANT	8	31,538
3.00	NURSING ADMINISTRATION	14	11,380
TOTAL RECLASSIFICATIONS FOR CODE G			49,549

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	49,549	
		0	
		0	
		49,549	

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION		BEGINNING BALANCES	PURCHASES	ACQUISITIONS DONATION	TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION		BEGINNING BALANCES	PURCHASES	ACQUISITIONS DONATION	TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	1,263,514	264,836		264,836		1,528,350	
7	SUBTOTAL	1,263,514	264,836		264,836		1,528,350	
8	RECONCILING ITEMS							
9	TOTAL	1,263,514	264,836		264,836		1,528,350	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS	CAPITIALIZED GROSS ASSETS	FOR RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
*		1	2	3	4	5	6	7
3	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV							
5	TOTAL				1.000000			

DESCRIPTION		SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	648,417	43,309		8,250	402,116	3,550	1,105,642
4	NEW CAP REL COSTS-MV	231,762		10,005	-2,150			239,617
5	TOTAL	880,179	43,309	10,005	6,100	402,116	3,550	1,345,259

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION		SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	420,064				402,116	3,550	825,730
4	NEW CAP REL COSTS-MV	37,707						37,707
5	TOTAL	457,771				402,116	3,550	863,437

- \* All lines numbers except line 5 are to be consistent with workhseet A line numbers for capital cost centers.  
(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on worksheet A, column 7, lines 1 thru 4.  
Columns 9 through 14 should include related worksheet A-6 reclassifications and worksheet A-8 adjustments. (See instructions).

## ADJUSTMENTS TO EXPENSES

 I PROVIDER NO:  
 I 14-4009  
 I

 I PERIOD:  
 I FROM 1/ 1/2009 I PREPARED 4/12/2010  
 I TO 12/31/2009 I WORKSHEET A-8

DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO 4	WKST. A-7 REF. 5
			COST CENTER 3			
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &		3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E		4	
5 INVESTMENT INCOME-OTHER						
6 TRADE, QUANTITY AND TIME DISCOUNTS						
7 REFUNDS AND REBATES OF EXPENSES						
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS						
9 TELEPHONE SERVICES						
10 TELEVISION AND RADIO SERVICE						
11 PARKING LOT						
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-248,597				
13 SALE OF SCRAP, WASTE, ETC.						
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	-27,468				
15 LAUNDRY AND LINEN SERVICE						
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-21,181	DIETARY		11	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS						
18 SALE OF MED AND SURG SUPPLIES						
19 SALE OF DRUGS TO OTHER THAN PATIENTS						
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-1,299	MEDICAL RECORDS & LIBRARY		17	
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)						
22 VENDING MACHINES	B	-1,350	OPERATION OF PLANT		8	
23 INCOME FROM IMPOSITION OF INTEREST						
24 INTRST EXP ON MEDICARE OVERPAYMENTS						
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**		49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**		50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3					
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**		89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES	A	228,353	NEW CAP REL COSTS-BLDG &		3	9
32 DEPRECIATION-NEW MOVABLE EQUIP	A	194,055	NEW CAP REL COSTS-MVBLE E		4	9
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**		20	
34 PHYSICIANS' ASSISTANT						
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**		51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**		52	
37 MISC INCOME	B	-4,539	ADMINISTRATIVE & GENERAL		6	
38 EDUCATION	A	-161,062	ADULTS & PEDIATRICS		25	
39 EDUCATION	A	-23	OTHER LONG TERM CARE		36	
40 MISCELLANEOUS	A	-219,687	ADMINISTRATIVE & GENERAL		6	
41 MISCELLANEOUS	A	-250	NURSING ADMINISTRATION		14	
42 MISCELLANEOUS	A	-4,526	SOCIAL SERVICE		18	
43 MISCELLANEOUS	A	-3,678	ADULTS & PEDIATRICS		25	
44 TRANSPORTATION	A	-95,740	ADMINISTRATIVE & GENERAL		6	
45 TRANSPORTATION	A	-45,492	NURSING ADMINISTRATION		14	
46 TRANSPORTATION	A	-890	OTHER LONG TERM CARE		36	9
47 PHYSICIAN BENEFITS	A	-7,953	EMPLOYEE BENEFITS		5	
48 WORKERS COMP INSURANCE	A	-72,557	EMPLOYEE BENEFITS		5	
48.01 LIABILITY INSURANCE	A	-330,402	ADMINISTRATIVE & GENERAL		6	
48.03 MEDICAL INSURANCE	A	-31,834	EMPLOYEE BENEFITS		5	
48.04 AUTO INSURANCE	A	-2,150	NEW CAP REL COSTS-MVBLE E		4	12
48.05 HOSPITAL LEASE	A	-1,464,000	ADMINISTRATIVE & GENERAL		6	
49						
49.01						
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,322,270				

(1) Description - all chapter references in this column pertain to CMS Pub. 15-I.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to worksheet A-7

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE EXPENSE	960,605	988,073	-27,468
2						
3						
4						
5		TOTALS		960,605	988,073	-27,468

\* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:  
THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	B	PSI	100.00	PSI	100.00
2		0.00			HEALTHCARE
3		0.00			
4		0.00			
5		0.00			

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

- INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
- CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
- PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
- DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
- INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
- DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
- OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

## PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:

I PERIOD:

I PREPARED 4/12/2010

I 14-4009

I FROM 1/ 1/2009

I WORKSHEET A-8-2

I

I TO 12/31/2009

I GROUP 1

	WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
	1	2	3	4	5	6	7	8	9
1	25	AGGR	310,367	77,202	233,165	154,100	1,768	130,985	6,549
2									
3									
4	6	AGGR	69,215	69,215					
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	379,582	146,417	233,165		1,768	130,985	6,549

## PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:

I PERIOD:

I PREPARED 4/12/2010

I 14-4009

I FROM 1/ 1/2009

I WORKSHEET A-8-2

I

I TO 12/31/2009

I GROUP 1

	WKSHT A LINE NO.		COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
			11	12	13	14	15	16	17	18
1	25	AGGR						130,985	102,180	179,382
2										
3										
4	6	AGGR								69,215
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
101		TOTAL						130,985	102,180	248,597

## COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
I 14-4009 I FROM 1/ 1/2009 I NOT A CMS WORKSHEET  
I I TO 12/31/2009 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	2	SQUARE FEET	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	ENTERED
8	OPERATION OF PLANT	1	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	6	PATIENT DAYS	ENTERED
10	HOUSEKEEPING	1	SQUARE FEET	ENTERED
11	DIETARY	7	MEALS	ENTERED
12	CAFETERIA	9	FTE'S SERVED	ENTERED
14	NURSING ADMINISTRATION	10	DIRECT NRSING HRS	ENTERED
17	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	ENTERED
18	SOCIAL SERVICE	6	PATIENT DAYS	ENTERED

## COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET B  
 I I TO 12/31/2009 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION 0	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	EMPLOYEE BENE FITS 5	SUBTOTAL 5a.00	ADMINISTRATIV E & GENERAL 6	OPERATION OF PLANT 8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	1,105,642	1,105,642					
005 NEW CAP REL COSTS-MVBLE E	239,617		239,617				
006 EMPLOYEE BENEFITS	1,236,749	6,685	1,512	1,244,946			
008 ADMINISTRATIVE & GENERAL	3,870,240	190,394	43,050	187,945	4,291,629	4,291,629	
009 OPERATION OF PLANT	1,015,078	65,611	14,835	14,336	1,109,860	289,265	1,399,125
010 LAUNDRY & LINEN SERVICE	134,123	12,718	2,876		149,717	39,021	21,110
011 HOUSEKEEPING	510,045	13,617	3,079		526,741	137,286	22,601
012 DIETARY	746,910	64,800	14,652	26,587	852,949	222,306	107,555
014 CAFETERIA							
017 NURSING ADMINISTRATION	1,182,454	62,161	14,055	105,438	1,364,108	355,530	103,175
018 MEDICAL RECORDS & LIBRARY	383,584	10,811	2,444	22,074	418,913	109,182	17,943
025 SOCIAL SERVICE	1,036,011	22,329	5,049	97,132	1,160,521	302,469	37,061
036 INPAT ROUTINE SRVC CNTRS							
041 ADULTS & PEDIATRICS	6,679,908	529,833	119,802	645,249	7,974,792	2,078,483	879,412
044 OTHER LONG TERM CARE	728,672	53,171	12,023	68,577	862,443	224,780	88,253
053 ANCILLARY SRVC COST CNTRS							
056 RADIOLOGY-DIAGNOSTIC							
059 LABORATORY	165,012	3,331	753		169,096	44,072	5,528
060 ELECTROCARDIOLOGY							
095 DRUGS CHARGED TO PATIENTS	833,874	9,491	2,146		845,511	220,367	15,753
098 OUTPATIENT PSYCH							
100 OUTPAT SERVICE COST CNTRS							
101 CLINIC	393,737	6,828	1,544	38,712	440,821	114,892	11,333
102 SPEC PURPOSE COST CENTERS							
103 SUBTOTALS	20,261,656	1,051,780	237,820	1,206,050	20,167,101	4,137,653	1,309,724
098 NONREIMBURS COST CENTERS							
100 PHYSICIANS' PRIVATE OFFIC		45,913			45,913	11,966	76,207
101 COMMUNITY RELATIONS	496,227	7,949	1,797	38,896	544,869	142,010	13,194
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
103 TOTAL	20,757,883	1,105,642	239,617	1,244,946	20,757,883	4,291,629	1,399,125

## COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET B  
 I I TO 12/31/2009 I PART I

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E
	9	10	11	12	14	17	18
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	209,848						
011 HOUSEKEEPING		686,628					
012 DIETARY		54,485	1,237,295				
014 CAFETERIA							
017 NURSING ADMINISTRATION		52,266			1,875,079		
018 MEDICAL RECORDS & LIBRARY		9,090				555,128	
025 SOCIAL SERVICE		18,774					1,518,825
036 INPAT ROUTINE SRVC CNTRS							
041 ADULTS & PEDIATRICS	181,771	445,496	1,007,192		1,618,132	462,029	1,315,614
044 OTHER LONG TERM CARE	28,077	44,707	155,572		197,080	18,244	203,211
053 ANCILLARY SRVC COST CNTRS							
056 RADIOLOGY-DIAGNOSTIC							
059 LABORATORY		2,800				9,947	
060 ELECTROCARDIOLOGY							
095 DRUGS CHARGED TO PATIENTS		7,980				29,666	
098 OUTPATIENT PSYCH							
100 OUTPAT SERVICE COST CNTRS							
101 CLINIC		5,741	74,531		59,867	35,242	
102 SPEC PURPOSE COST CENTERS							
103 SUBTOTALS	209,848	641,339	1,237,295		1,875,079	555,128	1,518,825
108 NONREIMBURS COST CENTERS							
109 PHYSICIANS' PRIVATE OFFIC		38,605					
110 COMMUNITY RELATIONS		6,684					
111 CROSS FOOT ADJUSTMENT							
112 NEGATIVE COST CENTER							
113 TOTAL	209,848	686,628	1,237,295		1,875,079	555,128	1,518,825

## COST ALLOCATION - GENERAL SERVICE COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET B
I		I	TO 12/31/2009	I	PART I

	COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP- DOWN ADJ	TOTAL
		25	26	27
	GENERAL SERVICE COST CNTR			
003	NEW CAP REL COSTS-BLDG &			
004	NEW CAP REL COSTS-MVBLE E			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
008	OPERATION OF PLANT			
009	LAUNDRY & LINEN SERVICE			
010	HOUSEKEEPING			
011	DIETARY			
012	CAFETERIA			
014	NURSING ADMINISTRATION			
017	MEDICAL RECORDS & LIBRARY			
018	SOCIAL SERVICE			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	15,962,921		15,962,921
036	OTHER LONG TERM CARE	1,822,367		1,822,367
	ANCILLARY SRVC COST CNTRS			
041	RADIOLOGY-DIAGNOSTIC			
044	LABORATORY	231,443		231,443
053	ELECTROCARDIOLOGY			
056	DRUGS CHARGED TO PATIENTS	1,119,277		1,119,277
059	OUTPATIENT PSYCH			
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	742,427		742,427
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	19,878,435		19,878,435
	NONREIMBURS COST CENTERS			
098	PHYSICIANS' PRIVATE OFFIC	172,691		172,691
100	COMMUNITY RELATIONS	706,757		706,757
101	CROSS FOOT ADJUSTMENT			
102	NEGATIVE COST CENTER			
103	TOTAL	20,757,883		20,757,883

## ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET B  
 I I TO 12/31/2009 I PART III

	COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS 0	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIV E & GENERAL 6	OPERATION OF PLANT 8
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS		6,685	1,512	8,197	8,197		
006	ADMINISTRATIVE & GENERAL	40,441	190,394	43,050	273,885	1,238	275,123	
008	OPERATION OF PLANT		65,611	14,835	80,446	94	18,544	99,084
009	LAUNDRY & LINEN SERVICE		12,718	2,876	15,594		2,501	1,495
010	HOUSEKEEPING		13,617	3,079	16,696		8,801	1,601
011	DIETARY		64,800	14,652	79,452	175	14,251	7,617
012	CAFETERIA							
014	NURSING ADMINISTRATION		62,161	14,055	76,216	695	22,792	7,307
017	MEDICAL RECORDS & LIBRARY		10,811	2,444	13,255	145	6,999	1,271
018	SOCIAL SERVICE		22,329	5,049	27,378	640	19,390	2,625
025	INPAT ROUTINE SRVC CNTRS							
036	ADULTS & PEDIATRICS		529,833	119,802	649,635	4,247	133,247	62,277
036	OTHER LONG TERM CARE		53,171	12,023	65,194	452	14,410	6,250
041	ANCILLARY SRVC COST CNTRS							
044	RADIOLOGY-DIAGNOSTIC							
053	LABORATORY		3,331	753	4,084		2,825	391
053	ELECTROCARDIOLOGY							
056	DRUGS CHARGED TO PATIENTS		9,491	2,146	11,637		14,127	1,116
059	OUTPATIENT PSYCH							
060	OUTPAT SERVICE COST CNTRS							
060	CLINIC		6,828	1,544	8,372	255	7,365	803
095	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	40,441	1,051,780	237,820	1,330,041	7,941	265,252	92,753
098	NONREIMBURS COST CENTERS							
100	PHYSICIANS' PRIVATE OFFIC		45,913		45,913		767	5,397
101	COMMUNITY RELATIONS		7,949	1,797	9,746	256	9,104	934
102	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	40,441	1,105,642	239,617	1,385,700	8,197	275,123	99,084

## ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET B  
 I I TO 12/31/2009 I PART III

	COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E
		9	10	11	12	14	17	18
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVICE	19,590						
010	HOUSEKEEPING		27,098					
011	DIETARY		2,150	103,645				
012	CAFETERIA							
014	NURSING ADMINISTRATION		2,063			109,073		
017	MEDICAL RECORDS & LIBRARY		359				22,029	
018	SOCIAL SERVICE		741					50,774
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	16,969	17,580	84,370		94,127	18,335	43,981
036	OTHER LONG TERM CARE	2,621	1,764	13,032		11,464	724	6,793
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY		111				395	
053	ELECTROCARDIOLOGY							
056	DRUGS CHARGED TO PATIENTS		315				1,177	
059	OUTPATIENT PSYCH							
	OUTPAT SERVICE COST CNTRS							
060	CLINIC		227	6,243		3,482	1,398	
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	19,590	25,310	103,645		109,073	22,029	50,774
	NONREIMBURS COST CENTERS							
098	PHYSICIANS' PRIVATE OFFIC		1,524					
100	COMMUNITY RELATIONS		264					
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	19,590	27,098	103,645		109,073	22,029	50,774

## ALLOCATION OF NEW CAPITAL RELATED COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET B
I		I	TO 12/31/2009	I	PART III

	COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		25	26	27
003	GENERAL SERVICE COST CNTR			
004	NEW CAP REL COSTS-BLDG &			
005	NEW CAP REL COSTS-MVBLE E			
006	EMPLOYEE BENEFITS			
008	ADMINISTRATIVE & GENERAL			
009	OPERATION OF PLANT			
010	LAUNDRY & LINEN SERVICE			
011	HOUSEKEEPING			
012	DIETARY			
014	CAFETERIA			
017	NURSING ADMINISTRATION			
018	MEDICAL RECORDS & LIBRARY			
	SOCIAL SERVICE			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	1,124,768		1,124,768
036	OTHER LONG TERM CARE	122,704		122,704
	ANCILLARY SRVC COST CNTRS			
041	RADIOLOGY-DIAGNOSTIC			
044	LABORATORY	7,806		7,806
053	ELECTROCARDIOLOGY			
056	DRUGS CHARGED TO PATIENTS	28,372		28,372
059	OUTPATIENT PSYCH			
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	28,145		28,145
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	1,311,795		1,311,795
	NONREIMBURS COST CENTERS			
098	PHYSICIANS' PRIVATE OFFIC	53,601		53,601
100	COMMUNITY RELATIONS	20,304		20,304
101	CROSS FOOT ADJUSTMENTS			
102	NEGATIVE COST CENTER			
103	TOTAL	1,385,700		1,385,700

## COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET B-1  
 I I TO 12/31/2009 I

COST CENTER DESCRIPTION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	RECONCILIATION	ADMINISTRATIVE E & GENERAL	OPERATION OF PLANT
	(SQUARE FEET	(SQUARE FEET	( GROSS SALARIES )		( ACCUM. COST	(SQUARE FEET )
	3	4	5	6a.00	6	8
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	139,092					
005 NEW CAP REL COSTS-MVB		133,316				
006 EMPLOYEE BENEFITS	841	841	11,535,603			
008 ADMINISTRATIVE & GENE	23,952	23,952	1,741,493	-4,291,629	16,466,254	
009 OPERATION OF PLANT	8,254	8,254	132,834		1,109,860	106,045
010 LAUNDRY & LINEN SERVI	1,600	1,600			149,717	1,600
011 HOUSEKEEPING	1,713	1,713			526,741	1,713
012 DIETARY	8,152	8,152	246,356		852,949	8,152
014 CAFETERIA						
017 NURSING ADMINISTRATIO	7,820	7,820	976,987		1,364,108	7,820
018 MEDICAL RECORDS & LIB	1,360	1,360	204,535		418,913	1,360
025 SOCIAL SERVICE	2,809	2,809	900,019		1,160,521	2,809
036 INPAT ROUTINE SRVC CN						
041 ADULTS & PEDIATRICS	66,654	66,654	5,978,842		7,974,792	66,654
044 OTHER LONG TERM CARE	6,689	6,689	635,430		862,443	6,689
053 ANCILLARY SRVC COST C						
056 RADIOLOGY-DIAGNOSTIC						
059 LABORATORY	419	419			169,096	419
060 ELECTROCARDIOLOGY						
095 DRUGS CHARGED TO PATI	1,194	1,194			845,511	1,194
098 OUTPATIENT PSYCH						
100 OUTPAT SERVICE COST C						
101 CLINIC	859	859	358,699		440,821	859
102 SPEC PURPOSE COST CEN						
103 SUBTOTALS	132,316	132,316	11,175,195	-4,291,629	15,875,472	99,269
104 NONREIMBURS COST CENT						
105 PHYSICIANS' PRIVATE O	5,776				45,913	5,776
106 COMMUNITY RELATIONS	1,000	1,000	360,408		544,869	1,000
107 CROSS FOOT ADJUSTMENT						
108 NEGATIVE COST CENTER						
109 COST TO BE ALLOCATED	1,105,642	239,617	1,244,946		4,291,629	1,399,125
104 (WRKSHT B, PART I)						
105 UNIT COST MULTIPLIER	7.948998		.107922		.260632	
106 (WRKSHT B, PT I)		1.797361				13.193691
107 COST TO BE ALLOCATED						
106 (WRKSHT B, PART II)						
107 UNIT COST MULTIPLIER						
108 (WRKSHT B, PT II)						
109 COST TO BE ALLOCATED			8,197		275,123	99,084
106 (WRKSHT B, PART III)						
107 UNIT COST MULTIPLIER			.000711		.016708	
108 (WRKSHT B, PT III)						.934358

## COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET B-1  
 I I TO 12/31/2009 I

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS )	CAFETERIA (FTE'S )SERVED	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E
	(PATIENT DAYS				(DIRECT )NRSING HRS	( )GROSS CHARGES	(PATIENT )DAYS
	9	10	11	12	14	17	18
GENERAL SERVICE COST							
003 NEW CAP REL COSTS-BLD							
004 NEW CAP REL COSTS-MVB							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENE							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVI	36,257						
010 HOUSEKEEPING		102,732					
011 DIETARY		8,152	38,581				
012 CAFETERIA				19,541			
014 NURSING ADMINISTRATIO		7,820		1,622	308,131		
017 MEDICAL RECORDS & LIB		1,360		453		49,502,511	
018 SOCIAL SERVICE		2,809		1,842			36,257
INPAT ROUTINE SRVC CN							
025 ADULTS & PEDIATRICS	31,406	66,654	31,406	12,784	265,907	41,200,529	31,406
036 OTHER LONG TERM CARE	4,851	6,689	4,851	1,557	32,386	1,626,877	4,851
ANCILLARY SRVC COST C							
041 RADIOLOGY-DIAGNOSTIC							
044 LABORATORY		419				887,011	
053 ELECTROCARDIOLOGY							
056 DRUGS CHARGED TO PATI		1,194				2,645,444	
059 OUTPATIENT PSYCH							
OUTPAT SERVICE COST C							
060 CLINIC		859	2,324	810	9,838	3,142,650	
SPEC PURPOSE COST CEN							
095 SUBTOTALS	36,257	95,956	38,581	19,068	308,131	49,502,511	36,257
NONREIMBURS COST CENT							
098 PHYSICIANS' PRIVATE O		5,776					
100 COMMUNITY RELATIONS		1,000		473			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	209,848	686,628	1,237,295		1,875,079	555,128	1,518,825
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER		6.683682				.011214	
(WRKSHT B, PT I)	5.787793		32.070060		6.085331		41.890531
105 COST TO BE ALLOCATED							
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
(WRKSHT B, PT II)							
107 COST TO BE ALLOCATED	19,590	27,098	103,645		109,073	22,029	50,774
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER		.263774				.000445	
(WRKSHT B, PT III)	.540309		2.686426		.353983		1.400392

## COMPUTATION OF RATIO OF COSTS TO CHARGES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET C
I		I	TO 12/31/2009	I	PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS					
36	ADULTS & PEDIATRICS	15,962,921		15,962,921	102,180	16,065,101
	OTHER LONG TERM CARE	1,822,367		1,822,367		1,822,367
41	ANCILLARY SRVC COST CNTRS					
44	RADIOLOGY-DIAGNOSTIC					
53	LABORATORY	231,443		231,443		231,443
56	ELECTROCARDIOLOGY					
59	DRUGS CHARGED TO PATIENTS	1,119,277		1,119,277		1,119,277
	OUTPATIENT PSYCH					
60	OUTPAT SERVICE COST CNTRS					
	CLINIC	742,427		742,427		742,427
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	19,878,435		19,878,435	102,180	19,980,615
102	LESS OBSERVATION BEDS					
103	TOTAL	19,878,435		19,878,435	102,180	19,980,615

## COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET C  
 I I TO 12/31/2009 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
36	ADULTS & PEDIATRICS	41,200,529		41,200,529			
	OTHER LONG TERM CARE	1,626,877		1,626,877			
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
53	LABORATORY	887,011		887,011	.260925	.260925	.260925
56	ELECTROCARDIOLOGY						
59	DRUGS CHARGED TO PATIENTS	2,645,444		2,645,444	.423096	.423096	.423096
	OUTPATIENT PSYCH						
60	OUTPAT SERVICE COST CNTRS						
	CLINIC		3,142,650	3,142,650	.236242	.236242	.236242
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	46,359,861	3,142,650	49,502,511			
102	LESS OBSERVATION BEDS						
103	TOTAL	46,359,861	3,142,650	49,502,511			

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET C
I		I	TO 12/31/2009	I	PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS					
36	ADULTS & PEDIATRICS	15,962,921		15,962,921	102,180	16,065,101
	OTHER LONG TERM CARE	1,822,367		1,822,367		1,822,367
41	ANCILLARY SRVC COST CNTRS					
44	RADIOLOGY-DIAGNOSTIC					
53	LABORATORY	231,443		231,443		231,443
56	ELECTROCARDIOLOGY					
59	DRUGS CHARGED TO PATIENTS	1,119,277		1,119,277		1,119,277
	OUTPATIENT PSYCH					
60	OUTPAT SERVICE COST CNTRS					
	CLINIC	742,427		742,427		742,427
101	OTHER REIMBURS COST CNTRS					
102	SUBTOTAL	19,878,435		19,878,435	102,180	19,980,615
103	LESS OBSERVATION BEDS					
	TOTAL	19,878,435		19,878,435	102,180	19,980,615

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET C
I		I	TO 12/31/2009	I	PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
36	ADULTS & PEDIATRICS	41,200,529		41,200,529			
	OTHER LONG TERM CARE	1,626,877		1,626,877			
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
53	LABORATORY	887,011		887,011	.260925	.260925	.260925
56	ELECTROCARDIOLOGY						
59	DRUGS CHARGED TO PATIENTS	2,645,444		2,645,444	.423096	.423096	.423096
	OUTPATIENT PSYCH						
60	OUTPAT SERVICE COST CNTRS						
	CLINIC		3,142,650	3,142,650	.236242	.236242	.236242
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	46,359,861	3,142,650	49,502,511			
102	LESS OBSERVATION BEDS						
103	TOTAL	46,359,861	3,142,650	49,502,511			

Health Financial Systems MCRIF32 FOR RIVER EDGE HOSPITAL  
 CALCULATION OF OUTPATIENT SERVICE COST TO  
 CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET C  
 I I TO 12/31/2009 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
53	LABORATORY	231,443	7,806	223,637			231,443
56	ELECTROCARDIOLOGY						
59	DRUGS CHARGED TO PATIENTS	1,119,277	28,372	1,090,905			1,119,277
	OUTPATIENT PSYCH						
60	OUTPAT SERVICE COST CNTRS						
	CLINIC	742,427	28,145	714,282			742,427
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	2,093,147	64,323	2,028,824			2,093,147
102	LESS OBSERVATION BEDS						
103	TOTAL	2,093,147	64,323	2,028,824			2,093,147

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC			
44	LABORATORY	887,011	.260925	.260925
53	ELECTROCARDIOLOGY			
56	DRUGS CHARGED TO PATIENTS	2,645,444	.423096	.423096
59	OUTPATIENT PSYCH			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	3,142,650	.236242	.236242
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	6,675,105		
102	LESS OBSERVATION BEDS			
103	TOTAL	6,675,105		

Health Financial Systems MCRIF32 FOR RIVER EDGE HOSPITAL  
 CALCULATION OF OUTPATIENT SERVICE COST TO  
 CHARGE RATIOS NET OF REDUCTIONS  
 SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET C  
 I I TO 12/31/2009 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
53	LABORATORY	231,443	7,806	223,637	781	12,971	217,691
56	ELECTROCARDIOLOGY						
59	DRUGS CHARGED TO PATIENTS	1,119,277	28,372	1,090,905	2,837	63,272	1,053,168
	OUTPATIENT PSYCH						
60	OUTPAT SERVICE COST CNTRS						
	CLINIC	742,427	28,145	714,282	2,815	41,428	698,184
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	2,093,147	64,323	2,028,824	6,433	117,671	1,969,043
102	LESS OBSERVATION BEDS						
103	TOTAL	2,093,147	64,323	2,028,824	6,433	117,671	1,969,043

Health Financial Systems MCRIF32 FOR RIVER EDGE HOSPITAL  
 CALCULATION OF OUTPATIENT SERVICE COST TO  
 CHARGE RATIOS NET OF REDUCTIONS  
 SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET C  
 I I TO 12/31/2009 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
41	ANCILLARY SRVC COST CNTRS			
44	RADIOLOGY-DIAGNOSTIC			
53	LABORATORY	887,011	.245421	.260044
56	ELECTROCARDIOLOGY			
59	DRUGS CHARGED TO PATIENTS	2,645,444	.398106	.422024
	OUTPATIENT PSYCH			
60	OUTPAT SERVICE COST CNTRS			
	CLINIC	3,142,650	.222164	.235347
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	6,675,105		
102	LESS OBSERVATION BEDS			
103	TOTAL	6,675,105		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET D
I		I	TO 12/31/2009	I	PART I

TITLE XVIII, PART A

PPS

WKST A	COST CENTER DESCRIPTION	CAPITAL REL COST (B, II) 1	OLD CAPITAL SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	NEW CAPITAL SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS				1,124,768		1,124,768
101	TOTAL				1,124,768		1,124,768

## APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
I 14-4009 I FROM 1/ 1/2009 I WORKSHEET D  
I I TO 12/31/2009 I PART I

## TITLE XVIII, PART A

PPS

WKST A	COST CENTER DESCRIPTION	TOTAL	INPATIENT	OLD CAPITAL	INPAT PROGRAM	NEW CAPITAL	INPAT PROGRAM
LINE NO.		PATIENT DAYS	PROGRAM DAYS	PER DIEM	OLD CAP CST	PER DIEM	NEW CAP CST
		7	8	9	10	11	12
25	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS	31,406	6,118			35.81	219,086
101	TOTAL	31,406	6,118				219,086

## APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET D
I	COMPONENT NO:	I	TO 12/31/2009	I	PART II
I	14-4009	I		I	

## TITLE XVIII, PART A

## HOSPITAL

## PPS

WKST A	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST	NEW CAPITAL RELATED COST	TOTAL CHARGES	INPAT PROGRAM CHARGES	OLD CAPITAL CST/CHRG RATIO	CAPITAL COSTS
LINE NO.		1	2	3	4	5	6
41	ANCILLARY SRVC COST CNTRS						
44	RADIOLOGY-DIAGNOSTIC						
53	LABORATORY		7,806	887,011	167,058		
56	ELECTROCARDIOLOGY						
59	DRUGS CHARGED TO PATIENTS		28,372	2,645,444	805,638		
	OUTPATIENT PSYCH						
60	OUTPAT SERVICE COST CNTRS						
	CLINIC		28,145	3,142,650			
	OTHER REIMBURS COST CNTRS						
101	TOTAL		64,323	6,675,105	972,696		

## APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

IN LIEU OF FORM CMS-2552-96(09/1996) CONTD  
I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
I 14-4009 I FROM 1/ 1/2009 I WORKSHEET D  
I COMPONENT NO: I TO 12/31/2009 I PART II  
I 14-4009 I  
PPS

TITLE XVIII, PART A		HOSPITAL	
WKST A	COST CENTER DESCRIPTION	NEW CAPITAL	
LINE NO.		CST/CHRG RATIO	COSTS
		7	8
41	ANCILLARY SRVC COST CNTRS		
44	RADIOLOGY-DIAGNOSTIC		
53	LABORATORY	.008800	1,470
56	ELECTROCARDIOLOGY		
59	DRUGS CHARGED TO PATIENTS	.010725	8,640
	OUTPATIENT PSYCH		
60	OUTPAT SERVICE COST CNTRS		
	CLINIC	.008956	
101	OTHER REIMBURS COST CNTRS		
	TOTAL		10,110

APPORTIONMENT OF INPATIENT ROUTINE  
SERVICE OTHER PASS THROUGH COSTS  
TITLE XVIII, PART A

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
I 14-4009 I FROM 1/ 1/2009 I WORKSHEET D  
I I TO 12/31/2009 I PART III  
PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					31,406	
101	TOTAL					31,406	

APPORTIONMENT OF INPATIENT ROUTINE  
SERVICE OTHER PASS THROUGH COSTS  
TITLE XVIII, PART A

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
I 14-4009 I FROM 1/ 1/2009 I WORKSHEET D  
I I TO 12/31/2009 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS	INPAT PROGRAM PASS THRU COST
25	ADULTS & PEDIATRICS	7	8
101	TOTAL	6,118	6,118

Health Financial Systems MCRIF32 FOR RIVER EDGE HOSPITAL  
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

IN LIEU OF FORM CMS-2552-96(07/2009)

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET D
I	COMPONENT NO:	I	TO 12/31/2009	I	PART IV
I	14-4009	I		I	

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A	COST CENTER DESCRIPTION	NONPHYSICIAN	MED ED NRS	MED ED ALLIED	MED ED ALL	BLOOD CLOT FOR
LINE NO.		ANESTHETIST	SCHOOL COST	HEALTH COST	OTHER COSTS	HEMOPHILIACS
		1	2	2.01	2.02	2.03
	1.01					
41	ANCILLARY SRVC COST CNTRS					
	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
53	ELECTROCARDIOLOGY					
56	DRUGS CHARGED TO PATIENTS					
59	OUTPATIENT PSYCH					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
	OTHER REIMBURS COST CNTRS					
101	TOTAL					

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
41	ANCILLARY SRVC COST CNTRS							
44	RADIOLOGY-DIAGNOSTIC							
53	LABORATORY			887,011			167,058	
56	ELECTROCARDIOLOGY							
59	DRUGS CHARGED TO PATIENTS			2,645,444			805,638	
	OUTPATIENT PSYCH							
60	OUTPAT SERVICE COST CNTRS							
	CLINIC			3,142,650				
	OTHER REIMBURS COST CNTRS							
101	TOTAL			6,675,105			972,696	

Health Financial Systems MCRIF32 FOR RIVER EDGE HOSPITAL  
 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE  
 OTHER PASS THROUGH COSTS

IN LIEU OF FORM CMS-2552-96(07/2009) CONTD  
 I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET D  
 I COMPONENT NO: I TO 12/31/2009 I PART IV  
 I 14-4009 I I

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A	COST CENTER DESCRIPTION	OUTPAT PROG	OUTPAT PROG	OUTPAT PROG	OUTPAT PROG	COL 8.01	COL 8.02
LINE NO.		CHARGES	D,V COL 5.03	D,V COL 5.04	PASS THRU COST	* COL 5	* COL 5
		8	8.01	8.02	9	9.01	9.02
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY	47					
53	ELECTROCARDIOLOGY						
56	DRUGS CHARGED TO PATIENTS	9					
59	OUTPATIENT PSYCH						
60	OUTPAT SERVICE COST CNTRS						
	CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL	56					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES &amp; VACCINE COSTS

I PROVIDER NO:	I PERIOD:	I PREPARED 4/12/2010
I 14-4009	I FROM 1/ 1/2009	I WORKSHEET D
I COMPONENT NO:	I TO 12/31/2009	I PART V
I 14-4009	I	I

## TITLE XVIII, PART B

## HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	1	1.02	2	3	4
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY	.260925	.260925			
53 ELECTROCARDIOLOGY					
56 DRUGS CHARGED TO PATIENTS	.423096	.423096			
59 OUTPATIENT PSYCH					
60 OUTPAT SERVICE COST CNTRS					
101 CLINIC	.236242	.236242			
102 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
104 PROGRAM ONLY CHARGES					
104 NET CHARGES					

TITLE XVIII, PART B

HOSPITAL

		All Other (1)	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr
	Cost Center Description	5	5.01	5.02	5.03	6
(A)	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY		47			
53	ELECTROCARDIOLOGY					
56	DRUGS CHARGED TO PATIENTS		9			
59	OUTPATIENT PSYCH					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
101	SUBTOTAL		56			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		56			

TITLE XVIII, PART B

HOSPITAL

	Outpatient Radiology	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services
Cost Center Description	7	8	9	9.01	9.02
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY				12	
53 ELECTROCARDIOLOGY					
56 DRUGS CHARGED TO PATIENTS				4	
59 OUTPATIENT PSYCH					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
101 SUBTOTAL				16	
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES				16	

TITLE XVIII, PART B		HOSPITAL		
		PPS Services 1/1 to FYE	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center Description		9.03	10	11
(A)	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC			
44	LABORATORY			
53	ELECTROCARDIOLOGY			
56	DRUGS CHARGED TO PATIENTS			
59	OUTPATIENT PSYCH			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
101	SUBTOTAL			
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-			
	PROGRAM ONLY CHARGES			
104	NET CHARGES			

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 12/31/2009	I	PART I
I	14-4009	I		I	

## TITLE XVIII PART A

## HOSPITAL

## PPS

## PART I - ALL PROVIDER COMPONENTS

1

## INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	31,406
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	31,406
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	31,406
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	6,118
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

## SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	16,065,101
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	16,065,101

## PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	41,200,529
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	41,200,529
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.389925
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,311.87
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	16,065,101

## COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO:	I PERIOD:	I PREPARED 4/12/2010
I 14-4009	I FROM 1/ 1/2009	I WORKSHEET D-1
I COMPONENT NO:	I TO 12/31/2009	I PART II
I 14-4009	I	I

## TITLE XVIII PART A

## HOSPITAL

## PPS

## PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	511.53
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	3,129,541
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	3,129,541

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
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42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT				
	HOSPITAL UNITS				
43	INTENSIVE CARE UNIT				
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				384,452
49	TOTAL PROGRAM INPATIENT COSTS				3,513,993

## PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	219,086
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	10,110
52	TOTAL PROGRAM EXCLUDABLE COST	229,196
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	3,284,797

## TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 X 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

## PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 12/31/2009	I	PART III
I	14-4009	I		I	

TITLE XVIII PART A

HOSPITAL

PPS

## PART III - SKILLED NURSING FACILITY, NURSING FACILITY &amp; ICF/MR ONLY

1

66 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE  
SERVICE COST  
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM  
68 PROGRAM ROUTINE SERVICE COST  
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM  
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS  
71 CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS  
72 PER DIEM CAPITAL-RELATED COSTS  
73 PROGRAM CAPITAL-RELATED COSTS  
74 INPATIENT ROUTINE SERVICE COST  
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS  
76 TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION  
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION  
78 INPATIENT ROUTINE SERVICE COST LIMITATION  
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS  
80 PROGRAM INPATIENT ANCILLARY SERVICES  
81 UTILIZATION REVIEW - PHYSICIAN COMPENSATION  
82 TOTAL PROGRAM INPATIENT OPERATING COSTS

## PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BED DAYS  
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 511.53  
85 OBSERVATION BED COST

## COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST		16,065,101			
87 NEW CAPITAL-RELATED COST	1,124,768	16,065,101	.070013		
88 NON PHYSICIAN ANESTHETIST		16,065,101			
89 MEDICAL EDUCATION		16,065,101			
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

## COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO:	I PERIOD:	I PREPARED 4/12/2010
I 14-4009	I FROM 1/ 1/2009	I WORKSHEET D-1
I COMPONENT NO:	I TO 12/31/2009	I PART I
I 14-4009	I	I

TITLE XIX - I/P

HOSPITAL

OTHER

## PART I - ALL PROVIDER COMPONENTS

1

## INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	31,406
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	31,406
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	31,406
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)	
6	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
7	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER	
8	DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)	
10	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER	
12	DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
13	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM	21,212
14	(EXCLUDING SWING-BED AND NEWBORN DAYS)	
15	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING	
16	PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
17	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING	
18	PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR	
19	YEAR, ENTER 0 ON THIS LINE)	
20	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING	
21	PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
22	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING	
23	PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR	
24	YEAR, ENTER 0 ON THIS LINE)	
25	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM	
26	(EXCLUDING SWING-BED DAYS)	
27	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
28	NURSERY DAYS (TITLE V OR XIX ONLY)	

## SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH	
18	DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER	
20	DECEMBER 31 OF THE COST REPORTING PERIOD	
21	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH	
22	DECEMBER 31 OF THE COST REPORTING PERIOD	
23	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER	
24	DECEMBER 31 OF THE COST REPORTING PERIOD	
25	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	15,962,921
26	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST	
27	REPORTING PERIOD	
28	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST	
29	REPORTING PERIOD	
30	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST	
31	REPORTING PERIOD	
32	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST	
33	REPORTING PERIOD	
34	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
35	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	15,962,921

## PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	41,200,529
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	41,200,529
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.387445
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,311.87
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM	15,962,921
	COST DIFFERENTIAL	

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 12/31/2009	I	PART II
I	14-4009	I		I	

TITLE XIX - I/P

HOSPITAL

OTHER

## PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	508.28
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	10,781,635
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	10,781,635

TOTAL  
I/P COST  
1

TOTAL  
I/P DAYS  
2

AVERAGE  
PER DIEM  
3

PROGRAM  
DAYS  
4

PROGRAM  
COST  
5

42 NURSERY (TITLE V & XIX ONLY)  
INTENSIVE CARE TYPE INPATIENT  
HOSPITAL UNITS  
43 INTENSIVE CARE UNIT  
44 CORONARY CARE UNIT  
45 BURN INTENSIVE CARE UNIT  
46 SURGICAL INTENSIVE CARE UNIT  
47 OTHER SPECIAL CARE

1

48	PROGRAM INPATIENT ANCILLARY SERVICE COST	772,362
49	TOTAL PROGRAM INPATIENT COSTS	11,553,997

## PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES  
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES  
52 TOTAL PROGRAM EXCLUDABLE COST  
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN  
ANESTHETIST, AND MEDICAL EDUCATION COSTS

## TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES  
55 TARGET AMOUNT PER DISCHARGE  
56 TARGET AMOUNT  
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT  
58 BONUS PAYMENT  
58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED  
AND COMPOUNDED BY THE MARKET BASKET  
58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET  
BASKET  
58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE  
LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN  
EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)  
OTHERWISE ENTER ZERO.  
58.04 RELIEF PAYMENT  
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT  
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)  
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1  
59.03 PROGRAM DISCHARGES AFTER JULY 1  
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)  
59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1  
(SEE INSTRUCTIONS) (LTCH ONLY)  
59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1  
(SEE INSTRUCTIONS) (LTCH ONLY)  
59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)  
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

## PROGRAM INPATIENT ROUTINE SWING BED COST

60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST  
REPORTING PERIOD (SEE INSTRUCTIONS)  
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST  
REPORTING PERIOD (SEE INSTRUCTIONS)  
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS  
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE  
COST REPORTING PERIOD  
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE  
COST REPORTING PERIOD  
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

## COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO:	I PERIOD:	I PREPARED 4/12/2010
I 14-4009	I FROM 1/ 1/2009	I WORKSHEET D-1
I COMPONENT NO:	I TO 12/31/2009	I PART III
I 14-4009	I	I

TITLE XIX - I/P

HOSPITAL

OTHER

## PART III - SKILLED NURSING FACILITY, NURSING FACILITY &amp; ICF/MR ONLY

1

66 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE  
SERVICE COST  
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM  
68 PROGRAM ROUTINE SERVICE COST  
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM  
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS  
71 CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS  
72 PER DIEM CAPITAL-RELATED COSTS  
73 PROGRAM CAPITAL-RELATED COSTS  
74 INPATIENT ROUTINE SERVICE COST  
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS  
76 TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION  
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION  
78 INPATIENT ROUTINE SERVICE COST LIMITATION  
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS  
80 PROGRAM INPATIENT ANCILLARY SERVICES  
81 UTILIZATION REVIEW - PHYSICIAN COMPENSATION  
82 TOTAL PROGRAM INPATIENT OPERATING COSTS

## PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BED DAYS  
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 508.28  
85 OBSERVATION BED COST

## COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST					
87 NEW CAPITAL-RELATED COST					
88 NON PHYSICIAN ANESTHETIST					
89 MEDICAL EDUCATION					
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

## INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET D-4
I	COMPONENT NO:	I	TO 12/31/2009	I	
I	14-4009	I		I	

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT
LINE NO.		TO CHARGES	CHARGES	COST
		1	2	3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		8,045,170	
41	ANCILLARY SRVC COST CNTRS			
44	RADIOLOGY-DIAGNOSTIC	.260925	167,058	43,590
53	LABORATORY			
56	ELECTROCARDIOLOGY	.423096	805,638	340,862
59	DRUGS CHARGED TO PATIENTS			
	OUTPATIENT PSYCH			
60	OUTPAT SERVICE COST CNTRS	.236242		
	CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		972,696	384,452
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		972,696	

## INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET D-4
I	COMPONENT NO:	I	TO 12/31/2009	I	
I	14-4009	I		I	

## TITLE XIX

## HOSPITAL

## OTHER

WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT
LINE NO.		TO CHARGES	CHARGES	COST
		1	2	3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		27,365,243	
41	ANCILLARY SRVC COST CNTRS			
44	RADIOLOGY-DIAGNOSTIC			
53	LABORATORY	.260925	545,106	142,232
56	ELECTROCARDIOLOGY			
59	DRUGS CHARGED TO PATIENTS	.423096	1,489,332	630,130
	OUTPATIENT PSYCH			
60	OUTPAT SERVICE COST CNTRS			
	CLINIC	.236242		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		2,034,438	772,362
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		2,034,438	

## CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO:	I PERIOD:	I PREPARED 4/12/2010
I 14-4009	I FROM 1/ 1/2009	I WORKSHEET E
I COMPONENT NO:	I TO 12/31/2009	I PART B
I 14-4009	I	I

## PART B - MEDICAL AND OTHER HEALTH SERVICES

## HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	16
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	26
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRU)	
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	26
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	5
18.01	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	21
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	21
24	PRIMARY PAYER PAYMENTS	
25	SUBTOTAL	21
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	21
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	21
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	21
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
TO BE COMPLETED BY CONTRACTOR		
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

## ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
 I 14-4009 I FROM 1/ 1/2009 I WORKSHEET E-1  
 I COMPONENT NO: I TO 12/31/2009 I  
 I 14-4009 I I

## TITLE XVIII

## HOSPITAL

## DESCRIPTION

INPATIENT-PART A P A R T B  
 MM/DD/YYYY AMOUNT MM/DD/YYYY AMOUNT  
 1 2 3 4

1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,072,428	21
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE	NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
ADJUSTMENTS TO PROVIDER .01			
ADJUSTMENTS TO PROVIDER .02			
ADJUSTMENTS TO PROVIDER .03			
ADJUSTMENTS TO PROVIDER .04			
ADJUSTMENTS TO PROVIDER .05			
ADJUSTMENTS TO PROGRAM .50			
ADJUSTMENTS TO PROGRAM .51			
ADJUSTMENTS TO PROGRAM .52			
ADJUSTMENTS TO PROGRAM .53			
ADJUSTMENTS TO PROGRAM .54			
SUBTOTAL .99		NONE	NONE
4 TOTAL INTERIM PAYMENTS		4,072,428	21
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
TENTATIVE TO PROVIDER .01			
TENTATIVE TO PROVIDER .02			
TENTATIVE TO PROVIDER .03			
TENTATIVE TO PROGRAM .50			
TENTATIVE TO PROGRAM .51			
TENTATIVE TO PROGRAM .52			
SUBTOTAL .99		NONE	NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01	85,084	
	SETTLEMENT TO PROGRAM .02		
7 TOTAL MEDICARE PROGRAM LIABILITY		3,987,344	21

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

## CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO:	I PERIOD:	I PREPARED 4/12/2010
I 14-4009	I FROM 1/ 1/2009	I WORKSHEET E-3
I COMPONENT NO:	I TO 12/31/2009	I PART I
I 14-4009	I	I

## PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS HOSPITAL

1	INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)	
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)	
1.02	ENTER FROM THE PS&R, THE IRF PPS PAYMENT	
1.03	MEDICARE SSI RATIO (IRF PPS ONLY) (SEE INSTR.)	
1.04	INPATIENT REHABILITATION FACILITY LIP PAYMENTS (SEE INSTRUCTIONS)	
1.05	OUTLIER PAYMENTS	
1.06	TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)	
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)	
INPATIENT PSYCHIATRIC FACILITY (IPF)		
1.08	NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)	4,351,971
1.09	NET IPF PPS OUTLIER PAYMENTS	
1.10	NET IPF PPS ECT PAYMENTS	
1.11	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)	
1.12	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.13	CURRENT YEARS UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.14	CURRENT YEARS UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.15	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.16	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	86.043836
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{((1 + (LINE 1.15/1.16)) \text{ RAISED TO THE POWER OF } .5150 - 1)\}$ .	
1.18	MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).	
1.19	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08, 1.09, 1.10 AND 1.18)	4,351,971
1.20	STOP LOSS PAYMENT FLOOR (LINE 1 x 70%)	
1.21	ADJUSTED NET PAYMENT FLOOR (LINE 1.20 x THE APPROPRIATE FEDERAL BLEND PERCENTAGE)	
1.22	STOP LOSS ADJUSTMENT (IF LINE 1.21 IS GREATER THAN LINE 1.19 ENTER THE AMOUNT ON LINE 1.21 LESS LINE 1.19 OTHERWISE ENTER -0-)	
1.23	TOTAL IPF PPS PAYMENTS (SUM OF LINES 1.01, 1.19 AND 1.22)	4,351,971
INPATIENT REHABILITATION FACILITY (IRF)		
1.35	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER 15, 2004. (SEE INST.)	
1.36	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.37	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.38	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.39	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.40	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	
1.41	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{((1 + (LINE 1.39/1.40)) \text{ RAISED TO THE POWER OF } .9012 - 1)\}$ .	
1.42	MEDICAL EDUCATION ADJUSTMENT (LINE 1.02 MULTIPLIED BY LINE 1.41).	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL (SEE INSTRUCTIONS)	4,351,971
5	PRIMARY PAYER PAYMENTS	
6	SUBTOTAL	4,351,971
7	DEDUCTIBLES	264,130
8	SUBTOTAL	4,087,841
9	COINSURANCE	170,613
10	SUBTOTAL	3,917,228
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERV)	100,165
11.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	70,116
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	19,994
12	SUBTOTAL	3,987,344
13	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
15	OTHER ADJUSTMENTS (SPECIFY)	
15.99	OUTLIER RECONCILIATION ADJUSTMENT	
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS	

## CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 12/31/2009	I	PART I
I	14-4009	I		I	

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS  
HOSPITAL

17	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
18	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	3,987,344
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
19	INTERIM PAYMENTS	4,072,428
19.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
20	BALANCE DUE PROVIDER/PROGRAM	-85,084
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)	
	IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

----- FI ONLY -----

50	ENTER THE ORIGINAL OUTLIER AMOUNT FROM E-3, I LN 1.05 (IRF) OR 1.09 (IPF).
51	ENTER THE OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)
52	ENTER THE INTEREST RATE USED TO CALCULATE THE TIME VALUE OF MONEY. (SEE INSTRUCTIONS).
53	ENTER THE TIME VALUE OF MONEY.

## CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET E-3	
I	COMPONENT NO:	I	TO 12/31/2009	I	PART III	
I	-	I		I		

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
1	COMPUTATION OF NET COST OF COVERED SERVICE			
2	INPATIENT HOSPITAL/SNF/NF SERVICES		11,553,997	
3	MEDICAL AND OTHER SERVICES			
4	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
5	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
6	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
7	SUBTOTAL		11,553,997	
8	INPATIENT PRIMARY PAYER PAYMENTS			
9	OUTPATIENT PRIMARY PAYER PAYMENTS			
10	SUBTOTAL		11,553,997	
11	COMPUTATION OF LESSER OF COST OR CHARGES			
12	REASONABLE CHARGES			
13	ROUTINE SERVICE CHARGES		27,365,243	
14	ANCILLARY SERVICE CHARGES		2,034,438	
15	INTERNS AND RESIDENTS SERVICE CHARGES			
16	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
17	TEACHING PHYSICIANS			
18	INCENTIVE FROM TARGET AMOUNT COMPUTATION			
19	TOTAL REASONABLE CHARGES		29,399,681	
20	CUSTOMARY CHARGES			
21	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
22	PAYMENT FOR SERVICES ON A CHARGE BASIS			
23	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
24	FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT			
25	BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
26	RATIO OF LINE 17 TO LINE 18			
27	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		29,399,681	
28	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		17,845,684	
29	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
30	COST OF COVERED SERVICES		11,553,997	
31	PROSPECTIVE PAYMENT AMOUNT			
32	OTHER THAN OUTLIER PAYMENTS			
33	OUTLIER PAYMENTS			
34	PROGRAM CAPITAL PAYMENTS			
35	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
36	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
37	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
38	SUBTOTAL		11,553,997	
39	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
40	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE		11,553,997	
41	XVIII ENTER AMOUNT FROM LINE 30			
42	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
43	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
44	EXCESS OF REASONABLE COST			
45	SUBTOTAL		11,553,997	
46	COINSURANCE			
47	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
48	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
49	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING			
50	BEFORE 10/01/05 (SEE INSTRUCTIONS)			
51	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
52	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING			
53	ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
54	UTILIZATION REVIEW			
55	SUBTOTAL (SEE INSTRUCTIONS)		11,553,997	
56	INPATIENT ROUTINE SERVICE COST			
57	MEDICARE INPATIENT ROUTINE CHARGES			
58	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
59	PAYMENT FOR SERVICES ON A CHARGE BASIS			
60	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
61	FOR PAYMENT OF PART A SERVICES			
62	RATIO OF LINE 43 TO 44			
63	TOTAL CUSTOMARY CHARGES			
64	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
65	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
66	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER			
67	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
68	OTHER ADJUSTMENTS (SPECIFY)		4,245,825	
69	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS			
70	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
71	SUBTOTAL		15,799,822	
72	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
73	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
74	TOTAL AMOUNT PAYABLE TO THE PROVIDER		15,799,822	
75	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
76	INTERIM PAYMENTS		15,846,022	
77	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
78	BALANCE DUE PROVIDER/PROGRAM		-46,200	
79	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)			

CALCULATION OF REIMBURSEMENT SETTLEMENT

IN LIEU OF FORM CMS-2552-96-E-3 (5/2008)  
I PROVIDER NO: I PERIOD: I PREPARED 4/12/2010  
I 14-4009 I FROM 1/ 1/2009 I WORKSHEET E-3  
I COMPONENT NO: I TO 12/31/2009 I PART III  
I - I I

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

TITLE XIX

HOSPITAL

OTHER  
TITLE V OR  
TITLE XIX  
1

TITLE XVIII  
SNF PPS  
2

IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

## BALANCE SHEET

I  
I  
IPROVIDER NO:  
14-4009

I PERIOD:

I FROM 1/ 1/2009 I

I TO 12/31/2009 I

PREPARED 4/12/2010

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	-47,351			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	3,128,442			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY				
8	PREPAID EXPENSES				
9	OTHER CURRENT ASSETS	143,641			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	3,224,732			
FIXED ASSETS					
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	2,606,995			
14.01	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	2,383,561			
18.01	LESS ACCUMULATED DEPRECIATION	-1,591,130			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	3,399,426			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS				
27	TOTAL ASSETS	6,624,158			

## BALANCE SHEET

I PROVIDER NO:	I PERIOD:	I PREPARED	4/12/2010
I 14-4009	I FROM 1/ 1/2009	I	
I	I TO 12/31/2009	I	WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	356,911			
29 SALARIES, WAGES & FEES PAYABLE	417,450			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	14,600			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	1,005,576			
36 TOTAL CURRENT LIABILITIES	1,794,537			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66	-39,317,325			
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES	-39,317,325			
43 TOTAL LIABILITIES	-37,522,788			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	44,146,946			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	44,146,946			
52 TOTAL LIABILITIES AND FUND BALANCES	6,624,158			

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET	G-1
I		I	TO 12/31/2009	I		

## STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND	SPECIFIC PURPOSE FUND
	1	2
	3	4
1 FUND BALANCE AT BEGINNING		39,192,915
2 OF PERIOD		
3 NET INCOME (LOSS)		4,954,031
4 TOTAL		44,146,946
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6 ADDITIONS (CREDIT ADJUSTM		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		44,146,946
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13 DEDUCTIONS (DEBIT ADJUSTM		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		44,146,946
PERIOD PER BALANCE SHEET		

	ENDOWMENT FUND	PLANT FUND
	5	6
	7	8
1 FUND BALANCE AT BEGINNING		
2 OF PERIOD		
3 NET INCOME (LOSS)		
4 TOTAL		
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6 ADDITIONS (CREDIT ADJUSTM		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13 DEDUCTIONS (DEBIT ADJUSTM		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		
PERIOD PER BALANCE SHEET		

## STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO:	I PERIOD:	I PREPARED
I 14-4009	I FROM 1/ 1/2009	I WORKSHEET G-2
I	I TO 12/31/2009	I PARTS I & II

## PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	41,200,529		41,200,529
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
8 00 OTHER LONG TERM CARE	1,626,877		1,626,877
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	42,827,406		42,827,406
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	42,827,406		42,827,406
17 00 ANCILLARY SERVICES	3,532,455		3,532,455
18 00 OUTPATIENT SERVICES		3,142,650	3,142,650
24 00 PHYSICIAN	183,370		183,370
25 00 TOTAL PATIENT REVENUES	46,543,231	3,142,650	49,685,881

## PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		23,080,153
ADD (SPECIFY)		
27 00 ADD (SPECIFY)		
28 00 BAD DEBTS	21,296	
29 00		
30 00		
31 00		
32 00		
33 00 TOTAL ADDITIONS		21,296
DEDUCT (SPECIFY)		
34 00 DEDUCT (SPECIFY)		
35 00		
36 00		
37 00		
38 00		
39 00 TOTAL DEDUCTIONS		
40 00 TOTAL OPERATING EXPENSES		23,101,449

## STATEMENT OF REVENUES AND EXPENSES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	4/12/2010
I	14-4009	I	FROM 1/ 1/2009	I	WORKSHEET	G-3
I		I	TO 12/31/2009	I		

## DESCRIPTION

1	TOTAL PATIENT REVENUES	49,685,881
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	21,682,403
3	NET PATIENT REVENUES	28,003,478
4	LESS: TOTAL OPERATING EXPENSES	23,101,449
5	NET INCOME FROM SERVICE TO PATIENTS	4,902,029
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	21,181
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	1,299
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	1,350
22	RENTAL OF HOSPITAL SPACE	23,636
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER INCOME	4,539
25	TOTAL OTHER INCOME	52,005
26	TOTAL	4,954,034
	OTHER EXPENSES	
27	ROUNDING	3
28		
29		
30	TOTAL OTHER EXPENSES	3
31	NET INCOME (OR LOSS) FOR THE PERIOD	4,954,031